Drug Abuse Treatment Policy
A Report to the Little Hoover Commission

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Introduction

As President of the California Society of Addiction Medicine and a physician in the full time practice of Addiction Medicine in California, I am here to share my concerns about impediments to effective drug and alcohol treatment in California.

Misinformation and social stigmatization continue to be the foundation upon which many of our drug and alcohol policies are based. No field of medicine is more legislatively and judicially constrained than Addiction Medicine. In no field is the evidence of etiology and treatment effectiveness more consistently ignored in the formulation of public policy. The title of this study, "Drug Abuse Treatment", by The Little Hoover Commission symbolizes the gap between evidence and perception.

If society is ever to be successful in minimizing the harmful effects of drug use and drug addiction, there must be a shift in the way we conceptualize these issues. As Timothy Condon, Ph.D. pointed out in testimony to the commission on April 25, 2002, **"drug abuse is a preventable behavior and drug addiction is a treatable disease of the brain"**. Drug abuse and drug addiction together constitute this nation's most significant public health problem. While alcohol and drug use and abuse may be primarily social and legal issues with medical consequences, addiction is a medical problem with social and legal consequences. As long as we fail to differentiate use and abuse from addiction our efforts will produce limited medical and societal benefit.

Medicine has done no better than government in effectively managing the problem of alcohol and drug abuse and addiction. Alcoholics alone, excluding those addicted to other drugs, consume 15% of the health care budget nationally (8). Thirteen per cent of breast cancers, 40% of traumatic injuries, 41% of seizures and 72% of cases of pancreatitis are directly related to alcohol abuse (9). Data from the Epidemiological Catchment Area study show that almost half of all alcoholics have a second psychiatric diagnosis.

The introduction to the report from the Center for Addiction and Substance Abuse summarizes the issues well: Governors and state legislatures have the largest financial, social and political interest in preventing and treating all substance abuse and addiction, whether it involves alcohol, tobacco or illegal drugs, and especially among children and teens. While the federal government has heavy responsibilities to fund biomedical research, classify and regulate chemical substances and interdict illegal drugs, the brunt of failure to prevent and treat substance abuse and the cost of coping with the wreckage of this problem falls most heavily on the backs of governors and state legislatures across America.

States that want to reduce crime, slow the rise in Medicaid spending, move more mothers and children from welfare to work and responsible and nurturing family life must shift from shoveling up the wreckage to preventing children and teens from abusing drugs, alcohol and nicotine and treating individuals who get hooked.

The next great opportunity to reduce crime is to provide treatment and training to drug and alcohol abusing prisoners who will return to a life of criminal activity unless they leave prison substance free and, upon release, enter treatment and continuing aftercare. The remaining welfare rolls are crowded with individuals suffering from substance abuse and addiction. The biggest opportunity to cut Medicaid costs is by preventing and treating substance abuse and addiction. Governors who want to curb child abuse, teen pregnancy and domestic violence in their states must face up to this reality: unless they prevent and treat alcohol and drug abuse and addiction, their other well-intentioned efforts are doomed (1).

Success at the population level will come only when the necessary resources are integrated in effective ways. There must be integration of care within health-care systems. But this alone will not insure success. The necessary social and judicial systems must be included in an integrated manner. Appropriate courts can act as catalysts as well as conduits to needed services.

Early experiences with the voter-mandated policy changes of Proposition 36 have provided some surprises and some insights. The offenders presenting to the courts have more prevalent and more severe psychiatric illness than was anticipated. They are more often homeless, unemployed and without family support. Success with this population will require the needs in each of these areas to be addressed. Effectively integrated services will be needed if we are to prove successful with this severely impaired population. Lessons learned here can serve us well as we look to the broader substance abuse policy issues we face.

In this instance it is reasonable to assign to the courts the additional treatment, medical and social service resources they require to effectively address the needs of this particular population. Domestic violence and child welfare can courts offer similar integrated services to additional populations with very high incidence of substance use problems. The emerging concept of therapeutic jurisprudence offers hope that such integrated systems can be effective in reducing the societal impact of substance use disorders.

See;
Casey, P & Rottman, D.B. (2000). Therapeutic Jurisprudence in the Courts. *Behavioral Sciences & the Law. 18, 445-457*

Public policies to address the problems of substance abuse in California must address several key areas in a coordinated fashion:

- Prevention
- Assessment
- Treatment level determination
- Program cost data
- Program effectiveness data
- Education of providers
- Licensing issues
- Funding mechanisms, both public and private

In the pages that follow I hope to provide some insight into possible directions. I have attached a CSAM working paper that was presented at ***"Exploring the Opportunities of Proposition 36 Conference"*** in Sacrament in December 2000. Many of the issues you face are the same. The paper is well researched and referenced and will provide helpful guidelines as you approach this historically important task.

I thank the members of the commission for the opportunity to meet with you and share my thoughts on the problems of substance abuse treatment policy in California. The 400 members of the California Society of Addiction Medicine stand ready to assist you in this undertaking.

Funding:

There is a large body of evidence that alcohol and drug problems result in societal costs of $400 billion per year. Much of this direct cost is already borne by employers and health plans. Workplace accidents, lost productivity, absenteeism, and the health care costs of treating the complications of drug addiction add substantially to their financial burden. The National Center for Addiction and Substance Abuse at Columbia University estimates state governments spent $81.3 billion in 1998 for substance abuse and addiction (1). Of every dollar spent, 96 cents went to shoveling up the wreckage of substance abuse and addiction. Only 4 cents of each dollar was used to prevent and treat the problem. In California, in 1998, state government spent $10.942 billion on substance abuse and addiction. This amounts to $339.63 for every person in the state (1). Only 4% of this amount was targeted to prevention and treatment.

There is currently no shortage of money being spent for substance use disorders and their social consequences.

Substance abuse treatment services can be made available to employees for $5.ll per year, or 43 cents per month (3). According to the actuarial firm of Millman and Robertson, substance abuse parity would increase premiums by less than one percent or less than $1 per family member per month (5). The Kaiser system in California provides treatment for substance use disorders on demand and at parity with other medical illness. Residential services in a social model program are also covered benefits. Costs, in that system, are consistent with the actuarial estimates of Millman and Robertson.

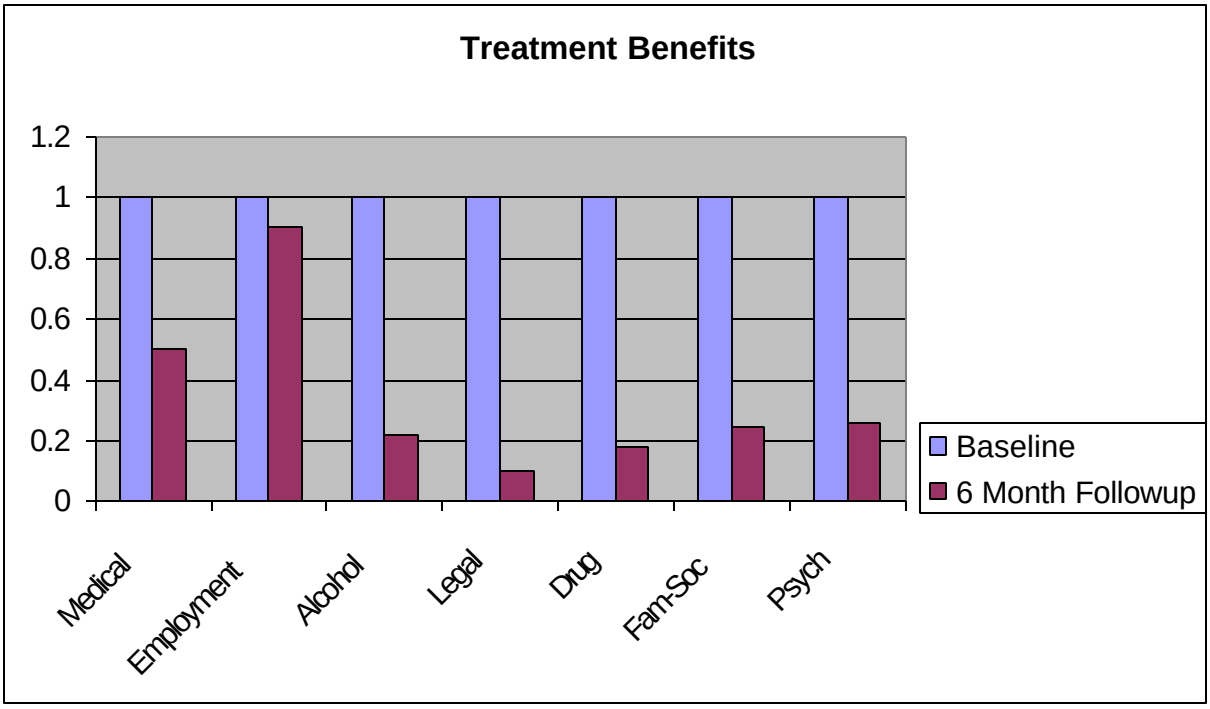
There is ample evidence that treatment for substance disorders produces reductions in subsequent health care utilization and cost. Data from a study at Kaiser's Sacramento Chemical Dependence Treatment Program, funded by NIAAA and NIDA, address the issues of cost and effectiveness for substance abuse treatment. In the *Journal of Studies on Alcohol* (62:89-97,2001), S. Parthasarathy and colleagues reported on the first 18 months post-treatment follow-up of 1,011 adult patients treated in an outpatient chemical dependency recovery program. Costs for hospital inpatient care, emergency room care, and outpatient medical care were measured for 18 months prior to treatment and compared with costs in the 18 months after treatment. Costs for these same services were also determined for 4,925 matched controls.

Medical care costs for the control group remained unchanged from the first to the second 18-month period. For the treated group, costs decreased by $31 per patient per month after treatment – a savings of $558 per patient over the post-treatment period. The total cost of treatment was $663 per patient for an eight-week period. During the treatment and post-treatment periods, the "net cost" (including the offset for reduced medical costs) was $105 per treated patient. When the net treatment cost is spread across the insured population of 3 million individuals, the result is a net cost of $2.52 per insured individual per year.

Improvement across a range of outcomes was measured at six months post-treatment with the Addiction Severity Index (ASI). Although employment-related problems showed only slight improvement, all remaining ASI scales demonstrated improvement ranging from 55 percent to 90 percent. In addition to the improvements in medical and psychiatric severity scales there were similar improvements the scales measuring family and legal problems. These translate to savings in governmental programs.

The improvement in the scale measuring severity of employment related problems lags behind the other improvements. Never the less, a Chevron Corporation analysis indicated that $10 was saved for every $1 spent on employee rehabilitation (6).

Clearly, there are both cost and outcome benefits from treatment for chemical dependence.



Weisner C, et al. Journal of Studies on Alcohol, 62 89-97, 2001

Public health issues, from tuberculosis and polio to HIV and anthrax, have always been addressed by a partnership between government and private sector interests. Drug abuse and drug addiction somehow became the primary responsibility of government.

We will never achieve adequate treatment access as long as we continue to assume that government alone is responsible for providing treatment.

Until employers and health plans do their part in contributing to the solution of these problems, our successes will be limited.

Parity for coverage of mental health problems, including alcohol and drug problems is an essential component of the solution.

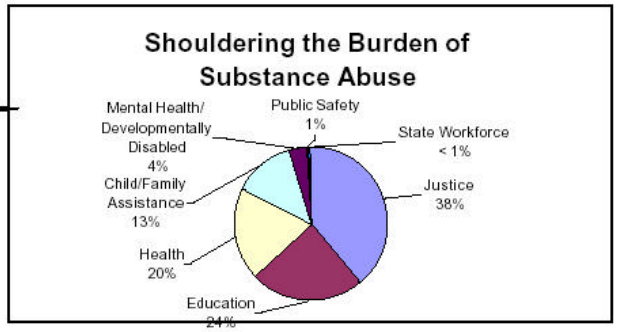
We are currently spending around $ 11 billion annually in California related to substance abuse and it's consequences. The Cal-Data study clearly showed public sector savings resulting from appropriate investments in treatment of substance use disorders. A 7 dollar saving was realized for each one dollar spent. If California decides to move toward public policies that focus on effective prevention and treatment models, cost savings will not be immediate. However:

The data suggest California can fund needed prevention and treatment initiatives and, ultimately, do so at a cost that is less than we are currently spending.

California

Summary of State Spending on Substance Abuse (1998)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Affected Programs:	***$51,567,629.9***	***$10,428,035.2***		***15.2***	***$323.67***
Justice	**4,955,896.0**	**4,053,556.7**		**5.9**	**125.82**
Adult Corrections	4,560,686.0	3,780,101.8	82.9		
Juvenile Justice	393,852.0	272,096.8	69.1		
Judiciary	1,358.0	1,358.0	100.0†		
Education (Elementary/Secondary)	**22,082,082.0**	**2,474,734.9**	**11.2**	**3.6**	**76.81**
Health	**8,310,362.0**	**2,040,249.0**	**24.6**	**3.0**	**63.33**
Child/Family Assistance	**6,039,691.0**	**1,404,025.2**		**2.1**	**43.58**
Child Welfare	976,837.0	709,247.7	72.6		
Income Assistance	5,062,854.0	694,777.5	13.7		
Mental Health/Developmentally Disabled	**1,455,865.0**	**368,168.5**		**0.5**	**11.43**
Mental Health	515,348.0	279,198.6	54.2		
Developmentally Disabled	930,517.0	88,969.9	9.6		
Public Safety	**220,115.0**	**58,300.1**	**26.5**	**0.1**	**1.81**
State Workforce	**8,513,618.9**	**29,000.9**	**0.3**	**<0.01**	**0.90**
Regulation/Compliance:	***41,555.0***	***41,555.0***	***100.0***	***0.1***	***1.29***
Licensing and Control	35,238.0	35,238.0			
Collection of Taxes	6,317.0	6,317.0			
Prevention, Treatment and Research:	***472,442.0***	***472,442.0***	***100.0***	***0.7***	***14.66***
Prevention	54,295.0	54,295.0			
Treatment	418,147.0	418,147.0			
Research	0	0			
Total		***$10,942,032.2***		***16.0***	***$339.63***



Total State Budget	$68,483 M
♦ Substance Abuse	$10,942 M
♦ Medicaid	$ 6,767 M
♦ Transportation	$ 4,062 M
♦ Higher Education	$ 8,152 M
Population	32.2 M

* Numbers may not add due to rounding. Tobacco and alcohol tax revenues total $954,096,000; $29.63 per capita.
† California only reported judiciary spending for drug courts.